

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555163	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/10/2026
NAME OF PROVIDER OR SUPPLIER  Shoreline Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  5225 South J Street Oxnard, CA 93033	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658  Level of Harm - Actual harm  Residents Affected - Few	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview and record review, the facility failed to transcribe and implement an x-ray as ordered by the physician in one out of three sampled residents (Resident 1) after Resident 1 sustained a fall. This failure resulted in a delay of treatment and care of a right hip fracture for Resident 1 that went unnoticed and untreated by the facility for 7 days. During a review of Resident 1's admission Record (AR) undated, the AR indicated Resident 1 was initially admitted to the facility on [DATE] with diagnoses including Anemia (condition where the body does not have enough healthy red blood cells), Dementia (a progressive state of decline in mental abilities), Depression (mood disorder that causes a persistent feeling of sadness and loss of interest), and Anxiety (mental health condition characterized by excessive worry, fear, and nervousness). During a review of Resident 1's Minimum Data Set (MDS - a standardized assessment and screening tool) dated 9/19/25, Section C indicated a brief interview of mental status score of 05 (BIMS - a measurement of cognitive abilities that ranges from 0 to 15 with scores of 0 - 7 indicates severe cognitive impairment). During an observation 1/6/26 3:25 p.m. in Resident 1's room, Resident 1 was observed awake in the wheelchair and well groomed. Resident 1 was asked about the fall incident but was unable to recall and stated, my memory is not good right now. During a review of Resident 1's Change in Condition Evaluation (CIC), dated 11/21/25, the CIC indicated Resident 1 had a fall onto her bottom. The CIC further indicated that the physician was notified with orders for a hip and sacrum (bone at the base of the spine) x-ray and an order for PRN (as needed) Tylenol 500 mg (milligrams) every 6 hours for pain. During a review Resident 1's Progress Notes (PN), PN dated 11/21/25 indicated Licensed Nurse (LN2) left a message with Resident 1's daughter regarding Resident 1's fall and new order for X- Ray to be taken the following day. Review of Resident 1's clinical records shows there were no orders for X- Ray taken following the fall as ordered by the physician. During a phone interview on 2/5/26 at 4:20 p.m., with Licensed Nurse (LN) 2, LN2 confirmed she was the nurse working during Resident 1's fall incident on 11/21/25. LN2 stated a Certified Nursing Assistant (CNA) was assisting Resident 1's roommate when Resident 1 was observed attempting to transfer from bed to wheelchair unassisted and subsequently fell onto her bottom. LN2 stated she notified the physician and received verbal orders, including an x-ray order. LN2 confirmed she did not transcribe the order or call the diagnostic company to perform the x-ray. LN2 stated I should have stayed late and called it in myself instead of assuming the next nurse was going to do it. LN2 acknowledged the x-ray was never done. During an interview on 1/6/26 at 2:55 p.m., with the Registered Nurse Supervisor (RNS), the RNS stated when a verbal x-ray order is received, the order is transcribed into the Electronic Health Record (EHR), a paper requisition form is completed, and the diagnostic company is called to be informed that there is an x-ray to be performed. RNS confirmed there are no x-ray results in Resident 1's medical records on or around 11/21/25. During an interview on 1/12/26 at 3:56 p.m., with the Director of Nursing (DON), DON stated Resident 1 did not complain of pain until</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0658  Level of Harm - Actual harm  Residents Affected - Few	11/28/25 during a transfer of the resident from wheelchair to bed, Resident 1 complaint of hip pain. It was at that time, during the review of medical records, that the facility discovered that the request for an x-ray of the hip was not performed. DON stated the x-ray was never done as ordered by the physician and it should have. Resident 1 was then later diagnosed with a right hip fracture after being transferred to the acute care hospital on [DATE].During a review of ED (Emergency Department) Physician Notes (EDPN), dated 11/29/25, the EDPN indicated [Resident 1] presents to the Emergency Department with pain to the right hip and knee. patient does have a intertrochanteric fracture noted on the right hip at this time. During a review of the facility's policy and procedure (P&P) titled Physician Orders, Telephone Orders and Recapitulation Process, dated 11/2024, the P&P indicated, The facility personnel receiving the verbal or telephone order shall transcribe the order into the PCC system.Review of [NAME] and [NAME], 7th Edition, Mosby's Fundamentals of Nursing, page 419 in the section titled, Legal Implications in Nursing Practice indicates, Nurses are obligated to follow physician order unless they believe the orders are in error or would harm clients.During a review of the facility's policy and procedure (P&P) titled Fall Prevention and Response, dated 08/2023, the P&P indicated, 9. When any Resident experiences a fall, the Interdisciplinary Team should. d. Coordinate appropriate care and referrals to address underlying circumstances, including. labs/diagnostics.		